Senior Whole Health, H5992, H2224
Dual Eligible Special Needs Plan

Model of Care Score: 93.75%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Senior Whole Health (SWH) serves full-benefit, aged and dual-eligible members. SWH offers a full range of coordinated medical, behavioral health and community-based services including acute and chronic care, preventive care, rehabilitation and supportive long-term and home care as defined by Medicare and Medicaid. This ethnically diverse population consists largely of beneficiaries who are poor, aged, frail, disabled, and chronically ill or near end of life. The average profile of a SWH member is a 76 year old female with five chronic care conditions and five prescription medications.

Provider Network

The SWH network is comprised of a combination of clinical professionals with expertise in dealing with older populations as well as facilities that care for this high risk population. Practitioner network specialties include, but are not limited to: internal medicine and family medicine, allied and ancillary providers, and behavioral health providers all whom have geriatric expertise. In addition, numerous facilities, including: hospital inpatient and outpatient units, skilled nursing facilities and long term care facilities and senior day care/adult day health facilities. Specific services are also provided like community nursing and home care services and adult care.

Care Management and Coordination

The initial health risk assessments (HRA) are composed of a community resource coordinator assessment, primary care provider (PCP) assessment, and geriatric support services assessment. These assessments are reviewed by the nurse case manager (NCM) assigned to the member. This initial assessment provides a baseline for the individualized care plan (ICP) and serves as a trigger for further assessment. Triggers include evidence of confusion, activities of daily living/independent activities of daily living (ADL/IADL) deficits, participates in adult day health (ADH), receives personal care services, skilled services in place, recent hospital admission or skilled nursing facility stay, reported dementia and one or more falls. If, during the initial evaluation, a member has at least one of the above triggers, further assessments are completed by the NCM. Once the initial assessment is complete, members are risk stratified into two risk severity groups – noncomplex and complex care. Initial assessments are completed upon enrollment with on-going re-assessments at least every 6 months.

ICPs are developed through the interdisciplinary care team (ICT), who coordinates the care of SWH members through a comprehensive, integrated and individualized care planning process directed by the PCP with the participation of the member or his/her legal designee. The nurse case manager is primarily responsible for leading the development of the ICP, working closely with the PCP and the other members of the ICT, and guiding implementation. This care plan incorporates the HRA, the PCP's clinical evaluation, and the member's input. Once approved by the PCP, the plan is reviewed with the member, or the member's designated representative and the member's caregivers and agreed upon by all parties. Throughout this process SWH authorizes the services identified in the evolving ICP and arranges for their implementation and monitoring. The ICP is updated as member status changes.

The composition of the ICT includes the member/caregiver, PCP, nurse practitioner, clinical staff, nurse case manager, community resource coordinator, geriatric services support coordinator, clinic pharmacists, behavioral health providers and other specialists. The ICT coordinates the care of SWH members through a comprehensive, integrated and individualized care planning process. The PCP is the focal point of clinical decision making with the participation of the member or his/her legal designee. The member's participation is facilitated by the ICT through home visits, face-to-face meetings, or telephone communication in the members preferred language. The care planning process integrates the member's goals with the recommendations and insights of all necessary and community service providers to establish a continuum of health-related services appropriate to both the needs and the residential setting of the member.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses member needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.seniorwholehealth.com.